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ABSTRACT

This collection of papers describes the interagency collaboration of Georgia agencies that serve students with emotional and behavior disorders (EBD). The first paper, "Overview and State Perspective" (P. Paulette Bragg and Phillip H. Pickens), describes the problems facing Georgia by placing students with EBD in state hospitals, private residential programs, and out-of-state facilities. The impact of legislation that was passed prohibiting out-of-state placements is described, along with a court case that resulted in the requirement that local school systems incorporate a reintegration plan for students who had been placed out-of-state. The second paper, "State Interagency Collaboration" (Ann Glendinning), provides data on student placement for fiscal years 1992-1997, summarizes the residential related services facilitator contract activities, and gives examples of state interagency activities which have been undertaken or enhanced since the creation of the residential facilitator position. "Behavioral Intervention Program" (Marty Smith), outlines the school-based collaborative program for students with severe behaviors and describes the reduction of intrusive interventions and the increase in proactive behavior supports. The last paper, "State and Private/Provider Perspective" (Ruth Coody), describes the creation of a mental health service system for children and adolescents with severe emotional disturbance. (CR)

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STATE AND LOCAL INTERAGENCY COLLABORATION--CREATING SERVICES FOR CHALLENGING STUDENTS

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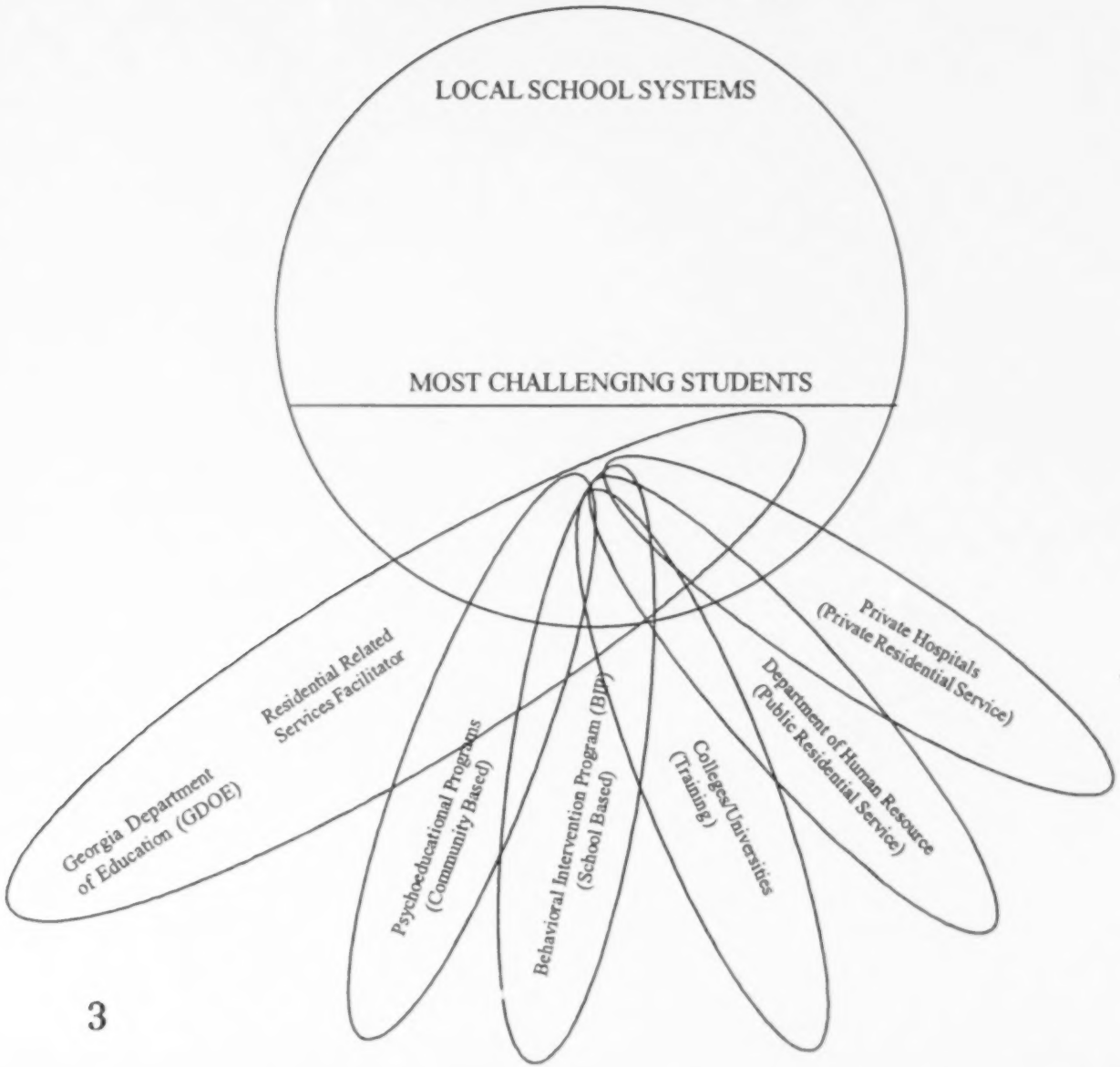
STATE AND LOCAL INTERAGENCY COLLABORATION--
CREATING SERVICES FOR CHALLENGING STUDENTS
(CEC, Salt Lake City - 4/13/97)


LOCAL SCHOOL SYSTEMS
MOST CHALLENGING STUDENTS
Georgia Department of Education (GDOE)
Residential Related Services Facilitator
Psychoeducational Programs (Community Based)
Behavioral Intervention Program (BIP) (School Based)
Colleges/Universities (Training)
Department of Human Resource (Public Residential Service)
Private Hospitals (Private Residential Service)

OVERVIEW AND STATE PERSPECTIVE

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In the middle to late 1980's, concerned Georgia citizens, educators, and legislators began asking questions and seeking answers about appropriate services for students with severe emotional and/or behavioral problems. For most students, the schools were managing to hold their own. Generally, for those students who were not successful in the resource, self-contained, or psychoeducational classes within the local school system, a combination of placements in state hospitals or in private residential programs were the options.

As the numbers of students being placed in these state and private facilities increased and the public and educational community became more and more aware of the increasing cost for the continued delivery within these systems, attention was focused on the types of students in need of such service and the determination of the provision of services in a cost effective manner.

At the same time, advocacy groups began questioning the therapeutic value and the ethics of removing students from the family and placing them in residential programs. Frequently, these placements were in locations out-of-state, thus reducing the contact between parents and child. As the advocates became stronger in their beliefs and worked with educators and legislators, a prolific number of bills were introduced impacting the rights of juveniles and their placements in programs as directed by education and other agencies.

During this same time span, similar concerns were being experienced by the human service provider agency, the Department of Human Resources (DHR), as advocacy groups and attorneys reviewed the placement and disposition of juveniles placed in hospital or institution settings. This review resulted in several pieces of legislation being passed which put very specific parameters on the DHR regarding admissions of children and youth into state-operated facilities and the disposition of the juveniles once placed. No longer were juveniles able to be placed in a DHR facility by parents or courts and left in that facility for lengthy periods without proper review. This led to a shift of the funding for DHR from large hospitals and institutions to community based programs. Juveniles who had been served in the hospitals and institutions were being released and sent back to the communities for services.

As could be anticipated, the services in the communities were not fully developed and, in many cases, the juveniles were released to communities with limited or no services. As juveniles either sought or were directed to mental health services, the DHR found that it could not keep the young people in the residential facilities for lengthy periods of time because of its new regulations, and ultimately families and students turned more and more to the local public schools for services.

Additionally, students were increasingly placed in out-of-state treatment facilities by DHR, due to limited space availability in-state. Legislation was passed, HB 560, which prohibited DHR from sending juveniles out-of-state and, within a five year period, required that DHR bring back all students currently placed out-of-state. Because of the

strength of this legislation, the DHR does not have any students currently in out-of-state placements. To make up for this elimination of out-of-state options, new programs have opened in Georgia, and the community resources have expanded and matured to the level that more appropriate services can be offered through the collaboration and cooperation of all the service providers.

The last significant issue impacting DHR was the issue of differentiating services for wards of the state and juveniles in the custody of their parents. Due to limited resources and the high costs of hospital and institutional placements, the numbers of juveniles who could be served by DHR was limited by the funding. This resulted in DHR being able to place only children and youth in treatment facilities who were in the custody of the state. For those youth in the custody of their parents, the agency had to take the position that parents would have to assume full financial responsibility. As a result, parents felt pressured to give up the custody of their children in order to secure service and, ultimately, placement through the state.

Again the advocates and the legislators bound together to find funding by limiting access to costly hospitalization and institutionalization and expanding the community resources. While this philosophy and direction made sense from the perspective of appropriate delivery of human services, the state found itself in the position of implementing a system of care before the system of care was fully constructed.

As the full implementation of the Education for All Handicapped Act (EHA) led to expanded and enhanced school services, parents and advocates began turning to the schools for assistance with their children who were in need of mental health/residential related services. Local school systems turned to the state DHR agency for assistance with placement of these students in existing state operated hospitals and institutions, only to find that the DHR was reducing the number of beds in these facilities and could only serve those who were in state custody.

With these regulatory and financial limitations and with the federal mandate of the EHA, local school systems sought placements in private residential programs and, in a large number of cases, the only placement that would accept the student was one outside the state. While this placement was often viewed as relieving the short- term crisis that the student, the school system, and the parents were experiencing, the relief was replaced with the frustration that the child was too far from home for meaningful visits, for generalization of new behaviors to natural settings, for parent training, and for transition planning.

As these forces all came to a head, Todd D, a young man in a local system with a long history of violent, destructive behavior, was denied admission into one of the DHR-operated facilities solely because the parents retained custody. The parents were extremely involved with their son and did not feel that they should be forced to relinquish custody to obtain service. The school system, unable to find a program, public or private, within the state which would accept Todd, placed the young man in a facility located in

Texas. The parents filed suit against the state agencies of education and human resources and against the local school system. The charges made were that the state had the responsibility to serve the student in the state and the parents should not be forced to give up custody.

The state agencies maintained that the individualized education program (IEP) was the appropriate document for the decision on services and that local school systems were the legally constituted body responsible for the implementation. The state education department had a clear oversight responsibility, but the local systems had the responsibility of IEP implementation. The parents and the local system believed the state through its oversight responsibility had the obligation to either provide directly or contract directly for the provision of service and thus relieve local school systems from the financial and legal responsibility.

Following a very lengthy legal process, the judge substantiated the obligation of the local school system as the body having direct responsibility for the implementation of the IEP, but made the following recommendations for the State Department of Education to operationalize:

1. The Georgia State Board of Education should adopt a rule which requires local school systems to incorporate the reintegration process as well as fully inform parents of in-state service options for those SED students who need residential related services.

   The following rule was approved by the State Board of Education.

   160-4-7-.14 REINTEGRATION PROCESS.

   (1) Requirements.

   (a) Each local school system (LSS) shall develop a reintegration plan for each student with a severe emotional disturbance (SED) who is placed in an out-of-state residential program according to the student's individualized educational program (IEP) and whose parents or guardian object to the out-of-state placement after having been informed of the possibility of placement in the state of Georgia.

   (b) The IEP and the reintegration plan shall be developed by the IEP placement committee.

   (c) When developing the reintegration plan, the IEP placement committee shall use the following procedure:

   1. Describe the needs of the student, and provide documentation for each need that has been determined to be clinically and/or educationally appropriate;

   2. Define the services to meet each need, and determine the least restrictive environment for the provision of services to meet the need;

   3. Review the location options for needed services, e.g., local, community, regional, or state;

4. Investigate the options available for provision of needed services, and further identify the appropriate and inappropriate options with documentation;

5. Determine the agency that is responsible for providing each service;

6. Determine the agency that is responsible for case management;

7. Negotiate the terms of service delivery with service providers; and

8. Specify the service providers to meet the student's needs.

(d) Each LSS shall coordinate with other public and private agencies the funding as appropriate for the necessary services. The Tuition Grant for Multihandicapped shall be available for funding special education and related services for those SED students who have been determined to need such services according to their IEPs and their reintegration plan.

(e) The Division for Exceptional Students (DES) shall provide technical assistance to LSSs to assist in the identification of SED students who are eligible for the reintegration process, to develop reintegration plans, and to locate available services.

2. The Georgia Department of Education/Division for Exceptional Students should provide expanded print information specifically to all superintendents, special education directors, local and state MATCH Committee members, and appropriate Department of Human Resources personnel on all approved/available in-state residential programs and other relevant information for SED students.

   This recommendation has resulted in expanded program descriptions and dissemination procedures.

3. The GDOE/DES and the DHR should collaborate to conduct specific training for implementing the reintegration process specifically for special education directors with SED students placed in out-of-state or in-state residential programs.

4. The GDOE/DES should fund or contract for the services of a facilitator to provide support directly to personnel dealing with residential related services in local school systems and the GDOE. This facilitator would serve as an ombudsperson to assist local school systems, local interagency committees, and GDOE in identifying alternative services, in providing information on negotiating service agreements with alternative service providers - both public and private, and in enhancing interagency collaboration efforts.

   Further information on the implementation of this recommendation will be described in detail later in the material.

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5. The GDOE should follow through with collaborative activities with the Georgia Department of Human Resources to implement the plan under O.C.G.A. § 49-5-220, consistent with the timelines and activities specified in the act.

6. The GDOE/DES should increase the flexibility of the funding procedures for the Tuition Grant Program when used for SED students requiring residential related services to encourage innovative in-state, community-based services (e.g., wrap-around services, adjusted living environments such as less than full-time residential related services, new cost sharing arrangements with DHR) while maintaining the requirements of P.L. 94-142 (as amended) and sharing costs between the local school system and the GDOE.

   The following is a copy of the amended regulations for the Tuition Grant Program.

   (10) Grant for Residential and Reintegration Services.

   (a) Authorization.

   1. The GBOE shall have authority to provide for implementation of other educational programs, additional personnel and/or funds not ordinarily within the prescribed curricula of the local school systems.

   2. The GBOE is authorized to establish priorities, standards and criteria for implementing and operating programs on a statewide basis as the board, in its discretion, finds necessary or desirable. Local school systems may, prior to implementation of these programs by the state board, implement programs locally in accordance with criteria and standards prescribed by the state board. The state board shall, upon implementation of such program, establish a uniform basis for allotment of additional personnel and funds if such additional allotments are necessary for operation of such programs.

   3. The local school systems in receipt of these grant funds shall ensure free appropriate public education for students with disabilities for this program.

   (b) Procedures.

   1. In the event that a local school system is unable to provide appropriate special education and related services to a student with disabilities within the boundaries of the local school system, within a regional program operated by the public school systems or within an educational setting operated by the State of Georgia, referral may be made to a private school or facility that is approved by the Georgia Department of Education.

   2. Private schools shall be in conformance with the due process procedures and shall also conform to the requirements of an individualized education program.

   3. Private schools to which students are recommended for placement shall meet applicable criteria that apply to public education agencies.

   4. The GBOE shall maintain and supply to LSSs, upon request, a list of private schools that meet applicable criteria.

5. Local school systems with students meeting criteria for the Residential and Reintegration Services Grant Program may be eligible to receive partial or total funding from the GBOE. The grant covers only educational costs, related services, and room and board. LSSs that apply for assistance shall assume full responsibility for the funding at the time of submitting an application. Grants are not automatically funded. Approval for grant applications, therefore, shall be based on the severity of the disability, and the availability of funds.

6. All applications shall be reviewed by staff of the GBOE with priority based on the following.

(i) Students with profound and severe disabilities requiring reintegration from a residential program.
(ii) Students with profound disabilities needing residential services.
(iii) Students with severe disabilities needing residential services.

7. All students placed in residential programs or in reintegration programs following full-time residential services shall be observed at least once a year by a representative of the LSS. This observation may coincide with the annual review. The progress reports and other related information for each student placed in residential programs shall be reviewed at mid-year as well as at the annual review, and reintegration issues considered at each review.

8. If a student who is currently funded through the Grant for Residential and Reintegration Services becomes the subject of a due process hearing, fiscal maintenance of the placement shall be continued, funds permitting; however, the local school system is still responsible for payment.

9. Educational costs for students meeting the special education grant program criteria shall be shared between the LSS and state education agency (SEA). The LSS shall assume a percentage of the total education cost equal to the percent of local funds utilized for the total educational program in the respective school district. The SEA shall maintain a record of the percent requirement for LSS and state participation in this program. It is the local education agency's responsibility to initiate and submit an application for these funds. The local school system may use other funds from public or private agencies to assist in the cost of educating a student in a private school or private facility, provided the services are arranged by the local school system.

10. All costs for those students identified as wards or who are in custody of the state shall be paid for by the SEA with state and federal funds.

Through the implementation of these recommendations and other activities which have followed, the Department of Education, through collaborative efforts with the Department of Human Resources and local school systems, has been able to expand the delivery options in state and provide quality services based on the unique needs of individual students.

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STATE INTERAGENCY COLLABORATION

Ann Glendinning
Residential Related Services Facilitator
The University of Georgia/Georgia Department of Education

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FY COMPARISONS

	Fiscal Years					
	97	96	95	94	93	92
Total Number of Residential Placements	38	45	46	48	57	79
In-State	25	31	35	31	31	40
Out-of-State	13	14	11	17	26	39
Total SED Students Placed	15	20	22	25	25	35
In-State	12	14	15	12	7	13
Out-of-State	3	6	7	13	18	22
Total SID/PID Students Placed	14	19	24	24	32	44
In-State	11	15	20	19	24	27
Out-of-State	3	4	4	5	8	17
Total Sensory Impaired Placed	4	4				
In-State	1	1				
Out-of-State	3	3				
Total Autistic Students Placed	5	2				
In-State	1	0				
Out-of-State	4	2				

(Data not reported by these categories.)

Summary of Residential Related Services Facilitator Contract Activities

- The total number of residential placements and the proportion of those placements which are out-of-state has declined over the past five years.
- The amount of state funds required for out-of-state residential placements has declined.
- Special education administrators report 21 residential placements were prevented or delayed because of information/assistance received through this grant and 27 residential placements were made in Georgia rather than out-of-state because of this service. At least 11 students were returned from an out-of-state to an in-state program.
- Seven new residential programs have been added to the list of programs in Georgia approved to serve students with disabilities placed through IEPs, and six more will be added by the beginning of the 1997-1998 school year. Several of the new programs are outside the metropolitan Atlanta area, and several serve populations not previously served in Georgia.
- The State Board of Education Rule governing the tuition grant was renamed and revised to allow more flexibility in the use of these funds for students requiring reintegration from a residential program or for a program designed to prevent a 24-hour residential placement. To date, five cases of reintegration plans and prevention plans have been supported through this grant.
- The application and approval process for private programs which wish to be approved to serve students placed through IEPs was revised and streamlined, with emphasis placed on special education programmatic considerations. In addition, cooperative approval procedures have been developed between Department of Human Resources and Department of Education for programs which serve youth placed through both agencies.
- Information and technical assistance has been provided to local special education administrators about the function and procedures of local interagency committees.
- Procedures to assure that DHR-placed students in private residential programs are afforded IDEA due process, when applicable, are under revision. In addition, mechanisms to enhance the access to public school programs for DHR-placed youth in out-of-home treatment placements are being refined and developed.
- Periodic meetings of the private residential service providers have been implemented to improve understanding of IDEA and state regulation requirements, provide a vehicle for improving the educational services in private treatment programs, improve the communication between local school systems and private programs, facilitate transition into and out of private programs for the students, and increase the awareness of the private program educational administrators regarding other approaches to delivery of services in the private sector by encouraging networking.

State Interagency Collaboration

While there has been a long-standing commitment to working together among the various child-serving state agencies, the implementation of a specific staff position as the point person for coordination of interagency efforts has streamlined this effort. The following are some examples of state interagency activities which have been either undertaken or enhanced since the creation of the residential facilitator position:

1. Department of Education (DOE) participation on the state Multi-Agency Team for Children (MATCH) Committee has increased and become more regular. MATCH is an interagency committee under the auspices of the Department of Human Resources which secures treatment services for seriously emotionally disturbed children and youth in Georgia. Increased participation has, in turn, led to an increased knowledge base of the MATCH staff on educational issues, facilitated the securing of pertinent educational records, improved the cooperation between treatment providers and the local school systems, and enhanced the educational services of the treatment programs.

2. Significant work has been completed toward the revision of six cooperative agreements and memoranda of understanding between agencies. Representatives from all relevant agencies and organizations have been fully involved in these revisions and useful dialogue and joint problem solving has occurred.

3. The facilitator has participated on several oversight teams, work groups, and long-range planning committees coordinated by other agencies. This has allowed for increased input on the educational needs of students who are under the care or supervision of other state agencies and an improved understanding about the issues arising in those agencies.

4. Because the state MATCH committee meets weekly, strong professional relationships have developed. As a result, members contact each other virtually daily for information, advice or assistance about perceived obstacles in services, policies, or procedures at the local and state levels. Many problems are dealt with in an informal and relatively quick manner.

5. The review of private treatment programs has been revised in a number of ways:

- Beginning in the 1997-1998 school year, all intermediate treatment facilities which admit children and youth placed by the Department of Human Resources (DHR) must be approved by the Division for Exceptional Students as being capable of serving students with IEPs. (The intensive treatment programs are already included in this review process.) As new programs develop in the state and request approval to receive state funded students, coordinated review of these programs is being undertaken.

- The DHR and DOE are coordinating efforts at promoting service expansion for populations which have been previously underserved in Georgia - dually diagnosed (MH/MR) children and youth, students with autism, youngsters with sexual abuse and sexual abuser histories, firesetters. Facilities are encouraged to develop step-down programs, so that intermediate treatment programs, therapeutic group homes, therapeutic foster homes, and evaluation programs are increasing significantly.

- The nature of these new programs requires increased coordination with local school districts, and avenues for this coordination are developing through clarification of local school system jurisdiction, joint planning meetings at the local level when new programs are developed, and meetings with each group of stakeholders to increase their understanding of the other parties' capabilities and needs.

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Behavioral Intervention Program

Marty Smith
Director
Behavioral Intervention Program

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BIP

BEHAVIORAL INTERVENTION PROGRAM

The Behavioral Intervention Program (BIP) is a Special Project that provides services at the local level for students with severe and challenging behaviors. The BIP is a collaborative program with the Georgia Department of Education, Clayton, Fulton, and Atlanta City Schools, and South Metro Psychoeducational Program.

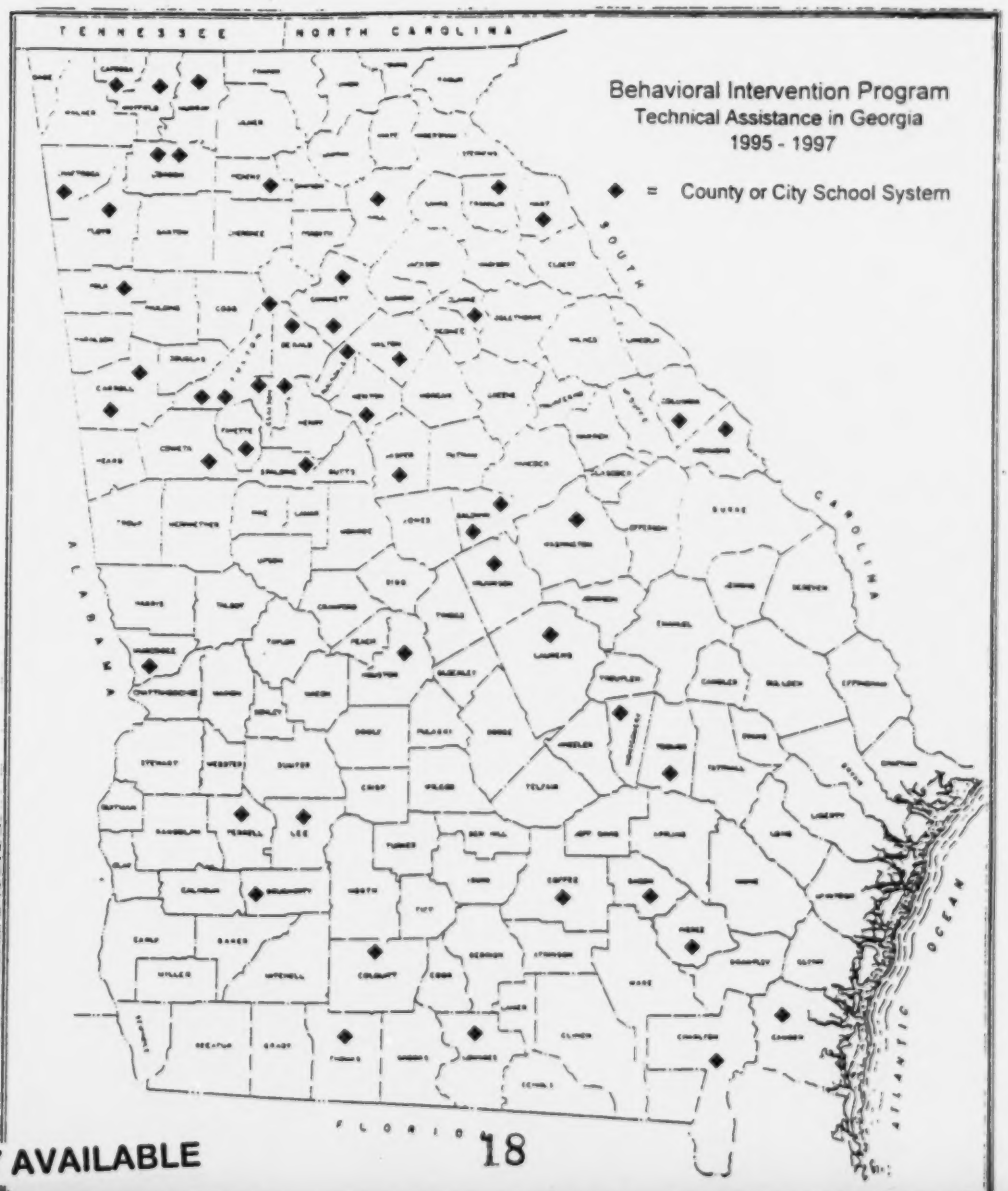
- *Technical Assistance to Georgia's School Programs*
- *Training in Effective Behavioral Assessment*
- *Collaboration to Provide Positive Behavioral Support*
- *Consumer Satisfaction*

While general classroom management methods are helpful for most students, a significant number of students require individualized behavioral support. These students exhibit such challenging behaviors as aggression, disruptive and destructive behavior, and self-injury. Students with severe behaviors are identified at the local level and referred to the BIP through a request for service process. A commitment of staff and time are made by the local school to establish a Behavior Support Team (BST) for participation in the BIP Technical Assistance training. The BST is typically comprised of the student's parents, teachers, related service personnel, supervisors, and administrators. The purpose of the team is to develop an effective behavior support plan for the student following the BIP technical assistance model.

- *Technical Assistance to School Programs*

Summary of Services for 1995-97

- ✓ *88 Students Served*
- ✓ *52 Local School Systems Assisted*
- ✓ *244 On-Site Visits by BIP Staff*
- ✓ *523 Members on Behavior Support Teams*



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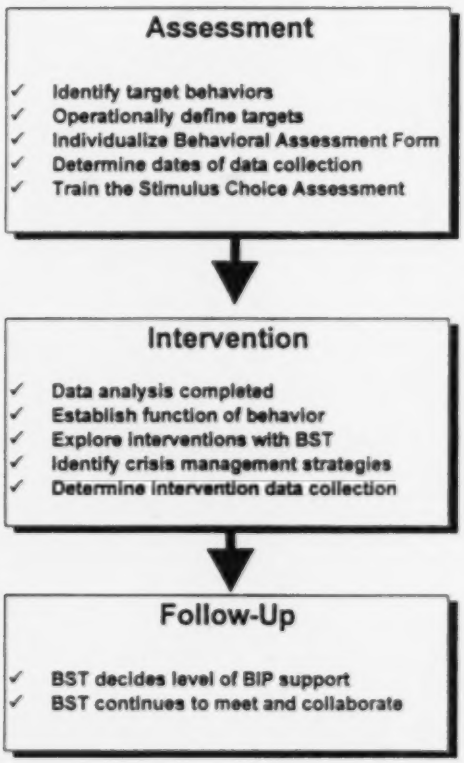
- *Training in Effective Behavioral Assessment*

Critical issues of BIP Technical Assistance Model:

A. To provide positive outcomes for students with severe disabilities and challenging behaviors.

B. To have a positive impact on the knowledge, skills, and behaviors of the individuals providing support to the student in the school setting.

BIP Technical Assistance Training Components


Assessment
✓ Identify target behaviors
✓ Operationally define targets
✓ Individualize Behavioral Assessment Form
✓ Determine dates of data collection
✓ Train the Stimulus Choice Assessment
Intervention
✓ Data analysis completed
✓ Establish function of behavior
✓ Explore interventions with BST
✓ Identify crisis management strategies
✓ Determine intervention data collection
Follow-Up
✓ BST decides level of BIP support
✓ BST continues to meet and collaborate

- *Collaboration to Provide Effective Behavioral Support*

Student Characteristics

Case Review Checklists were completed by BIP staff on twenty-two students referred for Technical Assistance during 1995-96. Information on these checklists was combined to study prevalent traits for these students. There were 68% male and 32% female subjects in this sample, with 12 years being the average age. Eligibility classifications were:

Autism	23%
Moderate ID	23%
Profound ID	18%
Severe ID	14%
Emo/Beh Disorder	14%
MID & SDD	8%

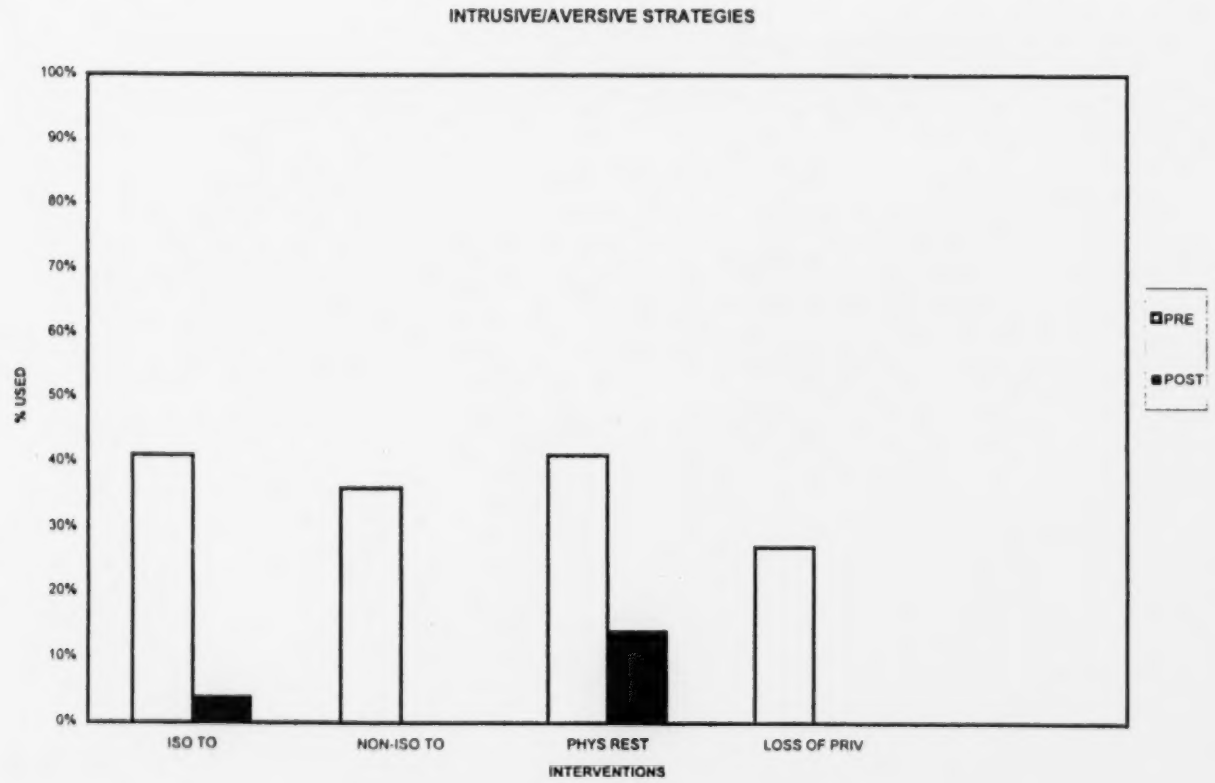
The majority of students, 74%, were placed in a self-contained special education class within a regular school, 18% were served in a psychoeduational program. A collaborative setting or preschool program served 8% of the referred students. Results of the functional assessments resulted in the following:

Avoidance/Escape	45%
Attention	20%
Control	5%
Sensory Needs	5%
Combinations	25%

Reductions in the Use of Intrusive Interventions

Intrusive/aversive behavioral methods result in inconsistent and very often undesirable outcomes. The BIP supports the assumption that interventions for persons with challenging behaviors should be those which are socially acceptable for students in general education. The graph below illustrates the reduction in the use of intrusive techniques through BIP Technical Assistance. The percentage of reduction for each was:

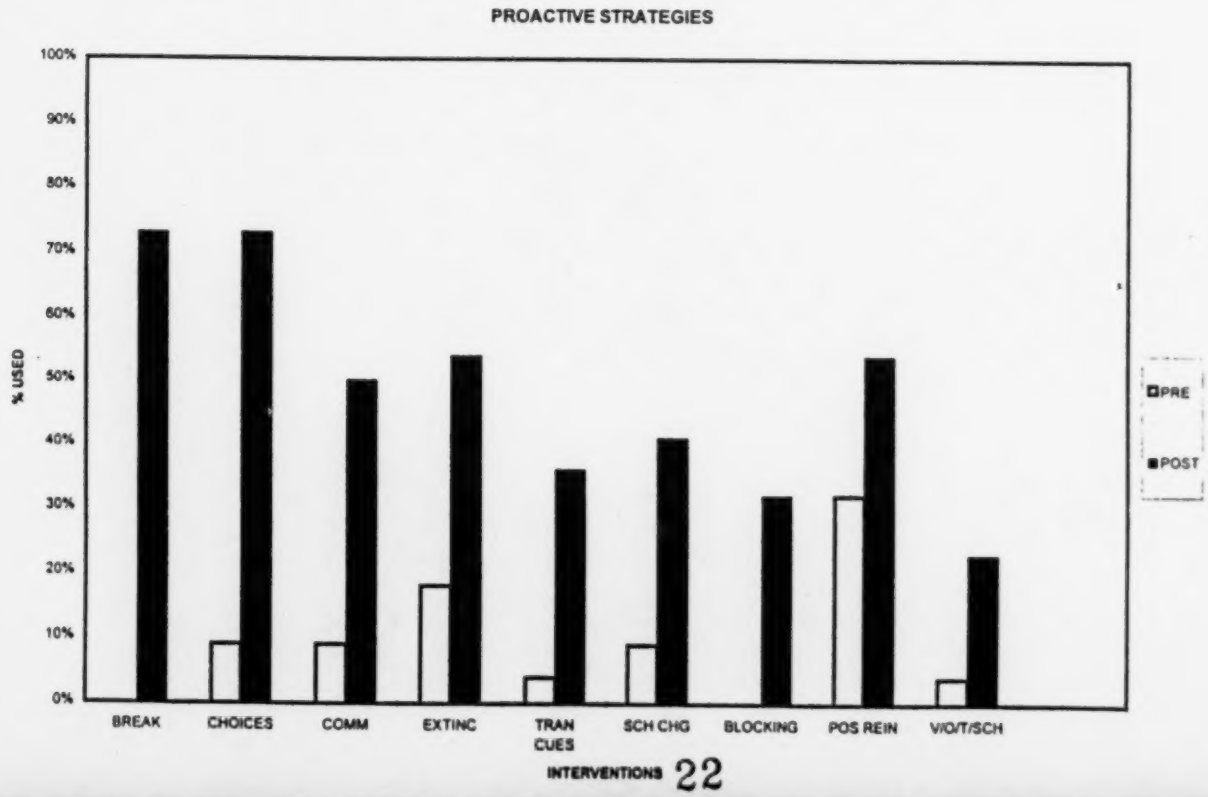
Isolated Time-Out	<37%
Non-Isolated Time-Out	<36%
Physical Restraint	<27%
Loss of Privileges	<27%



Increases in the Use of Proactive Behavior Support

Effective or proactive behavioral support has become the focus of intervention for students with severe and challenging behavior. These efforts result in long lasting change, improve the student's quality of life, and provide increased opportunities for these individuals. The reduction of problem behavior occurs as a result of teaching alternative skills and by modifying the student's environment. The percentage of increase for these types of behavioral supports was:

Breaks	>73%
Choices	>64%
Communication	>41%
Extinction	>36%
Transition Cues	>32%
Schedule Changes	>32%
Blocking	>32%
Reinforcement	>22%
Visual/Object/Tactile Schedule	>19%



• *Consumer Satisfaction*

Technical Assistance Surveys were completed by 75% of individuals who participated on Behavior Support Teams during 1996-97. The team member rated statements using the following scale:

Strongly Agree	5
Agree	4
Neutral	3
Disagree	2
Strongly Disagree	1

The responses for each statement on the surveys were compiled and the averages are reported below.

Technical Assistance Survey Results

1. *The BIP technical assistance model is designed to address the needs of local school systems serving students with severe behavior problems.*

4.6

2. *The BIP staff assisted the Behavior Support Team to develop an individualized behavioral assessment for the referred student.*

4.6

3. *The behavioral assessment data, when analyzed by the BIP staff, established the function/purpose of the student's target behaviors.*

4.5

4. *The intervention plans the team designed for the student were based on the results of the data collection and analysis.*

4.4

5. *The student's intervention plan utilized positive behavioral support strategies.*

4.6

6. *The team meetings with BIP staff provided a collaborative approach for learning new skills.*

4.5

7. *Following the BIP staff's involvement, the Behavior Support Team continues to meet as needed.*

3.8

For more information about the BIP contact:

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STATE AND PRIVATE/PROVIDER PERSPECTIVE

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STATE OF GEORGIA

Context Section

Demographic Characteristics

The state of Georgia is the largest state east of the Mississippi River. With a population of 6,478,216, according to the 1990 census, it is estimated that Georgia will be the tenth most populous state in the nation by the year 2000. Those persons classified as white compose 71% of the population, or 4,600,148 persons; black are 27% or 1,746,565; of Hispanic origin, 1.7% or 108,922; and other, 2% or 131,507 persons. People living in rural areas (less than 2500 inhabitants) comprise 36.8% of the population. Per capita income is $17,045 per year compared with a national average of $18,696. Approximately 18% earn less than $10,000 per year. Twenty-nine percent of the population has a high school degree, 13% completed college and 6% have post-graduate education.

Organization

The Georgia Department of Human Resources (DHR) was established in 1972, combining several former independent agencies. It is the legally designated agency responsible for mental health, alcohol, drug abuse and mental retardation services. DHR is comprised of several offices and major Divisions, those being Family and Children Services, Public Health Services, Aging Services, Rehabilitation Services, and Mental Health, Mental Retardation and Substance Abuse Services.

Georgia statute also establishes the Division of Mental Health, Mental Retardation and Substance Abuse (DMHMRSA) within DHR and mandates that it carry out certain activities to administer programs, train personnel, conduct research and protect clients rights. The DMHMRSA is the largest division within DHR. DMHMRSA directly operates 8 state psychiatric hospitals and, through 19 regional boards, contracts for community mental health services. The State Office of the Division provides statewide direction, planning, coordination, consultation, technical assistance and management support to all publicly operated or funded mental health, alcohol, drug abuse and mental retardation programs in Georgia.

Additionally, the State Office serves as the Division's planning and communications link with leadership of the DHR and with other state and federal agencies.

In addition, Georgia statute assigns specific responsibility for developing programs for children and adolescents to one or more units of the Division. Child and Adolescent services is a distinct entity within the Research, Development, Training and Redeployment Support Services Section of the Division. The functions of this entity are to provide statewide direction, planning, consultation and training to hospital and community programs, and coordination with other child serving agencies.

Georgia's purpose regarding mental health, mental retardation and substance abuse services according to Georgia statute is "to develop comprehensive, preventive, early detection, rehabilitative, and treatment disability services; to improve and expand community service board programs for the disabled; to provide continuity of care through integration of county, area, regional, and state services and facilities for the disabled; to provide for joint disability services and the sharing of manpower and other resources, and to monitor and restructure the system of providing disability services in the State of Georgia to make better use of the combined public and private resources of the state and local communities."

Legislation For System Reorganization and Change

In 1992, the Georgia legislature established the State Commission on Mental Health, Mental Retardation and Substance Abuse Services Delivery for the purpose of developing a comprehensive plan for improving the system. During FY93, legislation (House Bill 100) was passed by the Georgia General Assembly, as a result of the work and recommendations of the Commission, to reorganize the mental health system in the state. Two of the primary goals of House Bill 100 are to improve the service delivery system and to increase consumer and family choice and involvement.

The new legislation called for the formation of 19 regional boards, sub-state governing entities, established as the single point of accountability for fiscal and client service issues with the service delivery system. Each has responsibility for service system planning and needs assessment, service coordination, resource allocation, contracting for services, and monitoring of services and satisfaction beginning in FY96. Each board's membership is required to be composed of 50% consumers and family members. The remaining members are other citizens of the region. All counties in a region must have representation on the board.

The Regional Boards assumed responsibility on July 1, 1995 (FY 96) for selecting providers, and contracting for services according to locally determined needs. Prior to the passage of this legislation, the service system was split between two legal authorities, the state, which operated state institutions, and county boards of health which operated community programs.

The legislation also called for the creation of 27 (now 28) community service boards which have replaced the county board of health structure. These boards have the same membership requirement of 50% consumers and family members on the regional boards. The community service boards oversee the service delivery activities that are contracted to them, and can be contractors of regional boards. Regional boards also can contract with private agencies for services.

CREATION OF A MENTAL HEALTH SERVICE SYSTEM FOR CHILDREN AND ADOLESCENTS WITH SEVERE EMOTIONAL DISTURBANCE

To examine the status of the creation of the new service system, we need to begin with a look at the nation and Georgia prior to our first improvement funding for children and adolescents with severe emotional disturbance (SED) in FY89. (Nationally and in Georgia the mental health definition of SED is broader than the educational definition.) According to a Children's Defense Fund study:

- Two of three SED youth received no mental health services.
- Those who received services often received inappropriate ones, especially youth who had been in hospitals or were facing hospitalization, youth in out-of-home care under the custody of child welfare or juvenile justice agencies, youth from poor, disorganized families and youth with mentally ill, or substance abusing parents.
- In most states SED youth were a largely ignored group. Most states that were developing any services were focusing on traditional residential and hospital care.

In 1988 in Georgia, there was no real children's mental health system. A snapshot of services available at that time would have revealed the following:

- Limited outpatient services in the community programs, with some centers and most satellites having no child specific staff; 183 FTE (Full Time Equivalent) child and adolescent mental health staff in the community programs, including C&A program coordinators and doctors. The FTE count included many fractions of positions that served children part-time or occasionally.

- Funding for community mental health services was not separated by age category. A community mental health center was required to provide services to children and adolescents, but the amount of funding for those services was carved out of the total center budget for mental health services at the center's discretion.

- Caseloads were so full that on a statewide average a child could get approximately 30 minutes of attention (counseling, case coordination, charting, etc.) per week.

- Almost no services existed for a child that needed more than outpatient could offer, other than hospitalization. Most providers, both public and private, appeared to believe that youngsters whose problems could not be handled through outpatient services needed to be placed for "long-term residential treatment" or hospitalization.

- Children needing services from multiple providers (mental health, child welfare, juvenile justice, education, etc.) often did not receive services in a coordinated manner.

- Georgia's state hospitals had one of the highest admission rates for children in the nation and DHR had a steeply increasing rate and cost of placement for residential treatment through State MATCH (Multi-Agency Team for Children).

To change this picture the State is building, from the ground up, an adequate range of service components and attempting to coordinate those components with the services of the other child serving agencies (education, child welfare, juvenile justice, etc.) to create a "system of care" for SED youth.

STRATEGIES TO BUILD A SYSTEM OF CARE FOR CHILDREN AND ADOLESCENTS WITH SEVERE EMOTIONAL DISTURBANCE

1. Funding

Capacity Building Planning For Children and Adolescents

In the mid 1980's when Georgia received one of the first 10 NIMH Child and Adolescent Service System Program (CASSP) grants, Georgia's system of care for children and adolescents consisted mainly of outpatient/case management services, psychiatric hospital services and outdoor therapeutic services. There were a few slots of day treatment, family treatment home and therapeutic group home care available, but they were scattered around the state in different locations and there was no systematic plan for developing a statewide community-based system of care. There was not yet a strong focus on the severely disabled as a target population. Also the relationship between child and adolescent mental health and other child serving agencies (education, child welfare, juvenile justice) was more adversarial than cooperative or collaborative. In addition, neither families nor minorities were receiving any methodical attention.

In the 10 years since receipt of the CASSP grant, tremendous strides in improving the system of care for severely emotionally disturbed (SED) youth have been made in Georgia. The relationship with the other child serving agencies is now at least cooperative and many times it is collaborative, as witnessed by several interagency budget requests in the last few years and 102 local interagency committees which cover all of Georgia's 159 counties. In 1985 DMHMRSA adopted a most-in-need definition which focused the target population more toward the SED youngster.

Georgia also has a well developed multi-year capacity building plan for system development which encourages interagency coordination and has been able to gather significant amounts of new resources. The plan is community-based with an appropriate mix of non-residential and community residential services. The design for implementation of the plan uses strategies involving both state and federal financing and refocusing of directions at both the department and division levels. For example, the trend toward increasing resources going into restrictive residential treatment at the expense of community-based treatment has been reversed in the last four fiscal years.

The multi-year plan for children and adolescents was based on the extremely successful target area services plan for adults in Georgia. The successful strategy calls for substantial development of a "full package" or "critical mass" of services in sequential geographic areas. The keys to this strategy are (1) the measurable impact a full package of services can have in a single area, and (2) the cooperative advocacy efforts that develop as people in each area support all other areas' funding in turn under the plan.

In Georgia, this concept is understood and accepted by DHR (it has been used as the basis for an improvement request for child and adolescent mental health for 8 years), the Govenor's Office of Planning and Budget, and the State Legislature. Full statewide implementation of the proposed multi-year plan for children and adolescents has been estimated to require over $50 million. Funding realized through FY97 on an annualized basis is approximately $30 million.

The child and adolescent multi-year capacity building plan began in 1987 with a multi-agency planning process. A 30 member task force was formed that included DMHMRSA, Division of Family and Children Services (DFCS), Division of Youth Services (DYS, now the Department of Children and Youth Services), Division of Public Health (DPH), Department of Education (DOE), parents, minorities and the private sector. A research and planning consultant was used and a needs assessment was carried out in 1988. The needs assessment covered a 17 county region, which includes 3 area programs. It included a key informant survey, a client record survey, and an inventory of available services. A group of task force members worked on a core group of services and formulating a plan for services. Task force participants also discussed estimated costs for service components including staffing, training, and equipment.

The planning from the Northeast Consortium was used to develop a state capacity building plan. Other sources used were North Carolina's plan for children and adolescents, estimates from Robert M. Friedman of the Florida Mental Health Institute, and the FY90 planning from the 27 area programs. Following the development of a draft multi-year plan, DMHMRSA received feedback from parents/advocates, psycho educational center staff, multi-agency members of the Northeast Regional Planning Task Force, C&A Committee of the Governor's Advisory Council, and area MHMRSA C&A coordinators and staff.

In order to implement a capacity-building plan of this magnitude, both cost and time frames had to be considered. The level of services necessary for adequate capacity is more than can be realistically implemented in a single year. Therefore the plan spans a multi-year period. The first phase of the long range vision will achieve approximately half of the projected level of service. The second phase will be implemented after all regions have received approximately half of the services for adequate capacity. It is hoped that state appropriations will represent the major fund source. In addition, in lieu of state funds if necessary, Medicaid, block grant, MATCH (purchase of residential services), and other financing strategies are being utilized. Redirection of hospital funding is also being used in FY97 as areas build a critical mass of community-based services in sufficient quantity to impact hospitalization.

2. Legislation

House Bill 560

This legislation passed in 1990. It attempted to mandate that 1) DHR create new non-residential and residential mental health services for SED youth across the state, without additional funding; 2) coordination and collaboration between DHR and DOE at the state and local level; 3) children could not be placed out-of-state by either department unless all in-state resources were exhausted first; and 4) that all children placed out-of-state were to be returned to service in-state within a prescribed timeframe. The General Assembly passed the legislation as an unfunded mandate. The positive benefits of this legislation are as follows:

- Served as an impetus for DMHMRSA to obtain several years of funding by the General Assembly for its multi-year capacity building plan to develop new non-residential and residential mental health services for SED youth.

- DHR and DOE worked with in-state providers of residential treatment services to expand programming in order to return children from out-of-state and significantly impact the number of children being placed out-of-state. In the current fiscal year, only a small number of children are placed out-of-state.

3. **Consent Order**

J.L. - J.R. v. Parham, et al

The J.L. - J.R. v. Parham, et al lawsuit was filed in 1975. The term J.L - J.R. refers to the hospitalization and placement of children as required by the Consent Order on the settlement of the lawsuit. This lawsuit involved the psychiatric hospitalization of children and requested broad injunctive relief in the areas of procedural safeguards, periodic review procedures and placement in the least restrictive environment. As a result of the negotiations around this lawsuit, the DMHMRSA promulgated Rules and Regulations to deal with psychiatric admission, review, release and placement of minors. The philosophical thrust implicit in the lawsuit is that hospital admission for treatment shall be viewed as a temporary step for the purposes of necessary immediate psychiatric intervention, and shall not be viewed as a substitute for community-based treatment. Prior to the implementation of the Consent Order in 1983, the average length of stay in state hospitals for minors ranged from several months to years (both J.L. and J.R. were in a state hospital for over five years in the 1970's).

DHR and DMHMRSA utilized the lawsuit and Consent Order as a strategy to substantiate the need to fund the multi-year capacity building plan to develop new residential and non-residential mental health services for SED youth.

Impact of Developing Local Systems of Care

The state-initiated strategy of developing an array of community-based mental health services and attempting to coordinate those services with the services of the other child serving agencies (education, child welfare, juvenile justice, etc.) to create a system of care for SED youths has had the following results:

- Accessibility to public mental health services for children referred by education, child welfare, juvenile justice, etc. has increased drastically. As local communities received the state funds to develop an array of public mental health services, the state requested that mental health staff be outstationed in education facilities, child welfare offices, etc.

- Another key component to increase accessibility to mental health services was the restructuring of a Medicaid financing mechanism which the state initiated to help local public mental health service providers. The Department of Medical Assistance (Medicaid) made a change in their state plan to allow billing for public mental health services to be done outside the clinic office, thus enabling local public mental health services to be provided in locations outside the mental health center, such as in school facilities, child welfare offices, etc. This change in financing was allowed for children and adolescents only.

- Having access to a broad array of non-residential and residential public mental health services in the community has allowed more children to stay in their own homes or communities. Admissions to the state psychiatric facilities have decreased resulting in the closure of several beds and moving those funds to develop more community-based services.

- Several local public mental health providers have developed initiatives with other child caring systems (education, child welfare, juvenile justice, etc.) to strengthen their own integrative system building processes. Having a broader array of community services has allowed the public mental health providers to be more collaborative since they have more to offer children and their families than outpatient services or hospitalization in a state facility.